

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... or

Village ..... or

City *St. Louis* (NO. *City Hospital* 5 Ward)

Registration District No. **791**

File No. **22572**

Primary Registration District No. **1008**

Registered No. **5415**

2 FULL NAME *Christy Schuele*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Single* (Write the word)

6 DATE OF BIRTH *Dec 22 1875* (Month) (Day) (Year)

7 AGE *40 yrs 4 mos 21 ds* If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Seaman Day* (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) *Pennsylvania*

PARENTS 10 NAME OF FATHER *Not known* 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Not known* 12 MAIDEN NAME OF MOTHER *Not known* 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Not known*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Erman* (Address) *City Hospital*

15 Filed *JUN - 1 1916* *Max Lo Starloff* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 16 1916* (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *May 10 1916* to *May 16 1916*, that I last saw him alive on *May 15 1916*, and that death occurred, on the date stated above, at *8:05 A.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Pulmonary Tuberculosis*

(Duration) *28* yrs. mos. ds.

CONTRIBUTORY (Secondary) *28* (Duration) yrs. mos. ds.

(Signed) *B. W. Kupper* M. D.

*May 16 1916* (Address) *City Hospital*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *6* yrs. *6* mos. *17* ds. In the State *17* yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence *418 Lucas*

19 PLACE OF BURIAL OR REMOVAL *POTTERS FIELD* DATE OF BURIAL *JUN 2 1916*

20 UNDERTAKER *J. G. Peters* ADDRESS *1426 Carroll*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

